

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/29/2013	
NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 6/17/13.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00133948.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00130175 completed on 6/17/13.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00131168 completed on 7/24/13.</p> <p>Survey dates: August 28 and 29, 2013</p> <p>Facility number: 000369 Provider number: 155530 Aim number: 100275190</p> <p>Survey team: Cynthia Stramel, RN, TC Heather Tuttle, RN</p> <p>Census bed type: SNF/NF: 63 Total: 63</p> <p>Census Payor type: Medicare: 13 Medicaid: 49 Other: 1 Total: 63</p> <p>South Shore Health and Rehabilitation was found to be in compliance with 42 CFR Part 483,</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/29/2013
NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	Continued From page 1 Subpart B and 410 IAC 16.2 in regard to the PSR to the Recertification and State Licensure Survey. Quality review completed on September 5, 2013 by a Janelyn Kulik, RN.	{F 000}			